



NATUROPATHIC SPECIALISTS. LLC

PATIENT INFORMATION FORM

Name: _____ Date: _____

Date of birth: ____ / ____ / ____ Age: ____ SS#: ____ - ____ - ____

Address: _____

City: _____ State: _____ Zip: _____

(480 602 623)

(480 602 623)

(480 602 623)

Phones Home _____ Work _____ Mobile _____

Fax _____ E-mail address _____

Occupation _____ Name of Employer _____

Name of Spouse/Legal Guardian (circle one) _____

Emergency Contact Person

Name _____ Relationship to you _____

Phone number _____ Alternative number _____

Please choose Yes or No to the following and initial:

I authorize employees or agents of Naturopathic Specialists to leave a detailed message for me on a voice message device associated with the phone number listed below, regarding my:

- 1) **Laboratory reports** YES (initials _____) NO (initials _____)
2) **Protected health information** YES (initials _____) NO (initials _____)

If you answered **YES** to either of the above on which phone number is it acceptable to leave this information?

If you answered **NO** to either of the above, the physicians and/or staff members at Naturopathic Specialists will, as necessary, leave a message indicating your need to call the clinic to retrieve any of your health-related information.

Whom may we thank for referring you? _____

Drug Allergies: _____